THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION:

SOAH DOCKET NO. 453-04-5895.M5

MDR Tracking Number: M5-04-0770-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 11-12-03.

The IRO reviewed muscle energy technique, physician education services, physical med/rehab services, therapeutic activities, neurological re-education of movement, hot/cold packs, supplies and materials, manual traction, therapeutic exercises, ultrasound, myofascial release, mechanical traction, and joint mobilization from 4-18-03 through 7-18-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 2-27-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice. The requestor failed to submit relevant information to support components of the fee dispute in accordance with Rule 133.307(g)(3)(A-F). No reimbursement recommended for the fee portion.

This Decision is hereby issued this 9th day of April 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 4-18-03 through 7-18-03 in this dispute.

This Order is hereby issued this 9th day of April 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

February 24, 2004
Amended March 4, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #:	M5-04-0770-01
IRO #:	5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in

Physical Medicine and Rehabilitation. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___, a delivery truck driver employed by ___ suffered a work-related injury on ___.

DISPUTED SERVICES

Under dispute is the medical necessity of muscle energy technique, physician ed. services, physical med/rehab services, therapeutic activities, neurological reeducation of movement, hot/cold pack therapy, supplies and materials, traction manual, therapeutic exercises, ultrasound, myofascial exercises, mechanical traction and joint mobilization

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

Provided for review were records from the office of ___ and also a sufficiently large volume of records from the ___. These have all been reviewed in detail and appear to be appropriate for the patient problem presented. These coded activities applied to this patient do not appear improper or excessive. All items in question appear appropriate and reasonable, usual, and customary as pertaining to currently accepted physical therapy treatment regimens.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,